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SASKATCHEWAN HEALTH POLICY

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FOREWORD

INCLUDED in this pamphlet is a series of articles written by Miss Isabel Atkinson and published in the *Winnipeg Free Press* during October 1947, being a study of the Hospital services of Saskatchewan before and since the C.C.F. Government took office in 1944.

WHAT IS THE RECORD?

H EALTH services being provided by the C.C.F. government, are being held up as models. They are praised in other parts of Canada, in the U.S. and in the pro-Labor British press. What are the facts?

Do the services provide what was promised and what is claimed for them? Are they efficient? Are they economical? Above all, do they improve on what existed before?

Sufficient time has elapsed to consider the schemes in some detail; to see if the government has, in fact, implemented its pre-election pledges; and to study both the original proposals and the existing achievements.

To do this and to place the picture in proper perspective it is necessary to review the services which existed before those initiated by the C.C.F. government, and to glance at Dominion policy in this field.

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The outlines of federal government policy for health insurance are to be found in the Dominion proposals of August, 1945.

These proposals provide, among other things, for conditional grants-in-aid by the Dominion to those provincial governments which establish health insurance. The principle services covered would be general public health and preventive medicine such as inoculations, diagnostic, including clinical examination, medical and surgical treatment and hospital care. Only if an approved standard is reached will a province qualify for the grant.

Failure of the Dominion-provincial conference in 1945-46 has de-

ferred action on these proposals. Some of the provinces passed health insurance legislation. But because existing facilities and personnel were inadequate, and because they could not sustain the financial burden of such a scheme without Dominion aid, these acts were not to become effective until the Dominion proposals were adopted. So much for the Dominion.

As to Saskatchewan, that province is credited in Public Health circles with having developed before the C.C.F. came to power, very effective medical and hospital services. These were, in fact, a form of municipal health insurance developed before that term came into popular use. Only by such services could many of the rural communities provide the care sick people required.

They were a natural growth of prairie life although without the vision and enterprise of some of our rural people they would never have come into existence and without their persistence they could not have been maintained.

Nothing quite like them developed elsewhere and, in range of hospital, medical and surgical services rendered, they surpassed the similar achievements of Manitoba and Alberta. The standard of professional care was high. Costs varied, with the average surprisingly low. Maximum rates were less than had to be paid for comparable services elsewhere.

These services survived with difficulty the strains of a prairie economy. They spread from district to district. At the end of 1943, about 160 rural municipalities and close to 100 towns and

villages had one form or another, sometimes all three, of the various municipal medical, surgical and hospital services. Most of these communities still depend on services built up in this way, although hospitalization is now paid for under the provincial plan.

In addition to the municipal health services there were organizations serving cities and adjacent areas, such as Medical Services, and Medical Co-ops., Inc.

Although these services did not satisfy completely the public demand, they do demonstrate that the demand had grown over many years and that much had been done to meet it. As people found what it was possible to do, they gained a new vision of what might be achieved and raised their sights.

Not all communities availed themselves of these methods. But, where they were once adopted they were not willingly relinquished. During the 30's, (those years of endurance) municipal health services suffered almost unbearable strain. In spite of this, they continued to grow.

Between 1930 and 1940 accommodation in approved hospitals increased 42 per cent. (from 3,028 beds in 1930 to 4,315 in 1940) and the number of patients cared for, many of them under tax-paid hos-

pitalization plans, showed an increase of 48 per cent. (from 58,134 in 1930 to 86,008 in 1940).

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The demand for Dominion health insurance was one result of the experience of the 'thirties. People were determined that never again should an economic crisis be allowed to jeopardize their health services. They felt they must be extended until they served the whole province and their financial base must be strengthened. Dominion Health Insurance would meet these demands and would come to prairie people as a natural development of existing municipal services.

People who had built up municipal services had no doubt of the possibilities of Dominion Health Insurance. Each of the prairie governments welcomed the proposal, Saskatchewan being the first province to enact a bill to fit into the Dominion plan.

This was the situation when the C.C.F. government was elected. Its leaders had denounced the existing health services. They promised a new deal in this field. Complete free health services of every type were to be provided, without delay, for every resident of Saskatchewan.

How has this promise been kept?

C.C.F. PLANNING

TO those familiar with health services, pre-C.C.F. Saskatchewan seemed to have laid the foundation for a thorough province-wide expansion. The services were moderate in cost, efficient and up to a good standard, well-

adapted, under local control, to local needs. They had been praised by public health officials across Canada and elsewhere.

In spite of this, during the long campaign which built up the C.C.F. party, a judicious use of

official figures, often years out-of-date, obscured and darkened the picture. Two instances of this may be quoted as typical.

The 1944 election campaign reports of Mr. Douglas' speeches contained repetitions of the same statistical figures. Audiences were told that Saskatchewan's record of "unattended births" (where no physician or nurse was present) was shockingly high, being 27.4 per cent., while infant mortality at 67 per thousand of live births was disgraceful.

The first of these figures was the ten-year old record for 1934, a year when depression was at its worst. By 1943, a definite policy, persistently followed, had reduced this figure to 11.8 per cent. The latest infant mortality figures were then those for 1942, when Saskatchewan's rate was 43 per thousand.

Both these figures were easily available, but in each case the highest figure for a ten-year period was selected purely for political purposes, to support a charge of government neglect which use of current records would have made ridiculous.

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After the election, Mr. Douglas became minister of health as well as premier. One of his first official acts was to appoint a commission to survey health services. Blueprints for a new and better service were asked for, not merely an extension of the existing system. Such a survey called for highly-qualified experts in the organization and administration of Public Health. The man appointed to head this commission was Dr. Henry E. Sigerist, an eminent authority in his own field, the

History of Medicine, and lecturer in that subject at Johns Hopkins university. Acting with him were representatives of provincial medical, nursing, dental and hospital associations, but neither the chairman nor any member had a degree in public health or experience in its administration.

Sittings of the commission began on Sept. 6, 1944, and ended Oct. 5, less than a month later. A fourteen page report, with brief recommendations, dated Oct. 4, was published. In the light of the need, and of customary procedure, both the survey and the report were hasty, superficial and inadequate.

Preliminary legislation based on this report was passed in the fall of 1944 and supplemented at later sessions. As had been recommended, it authorized division of the province into "Health Regions" and the appointment of a Health Services Planning Commission.

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This Commission was one of the most important ever appointed in Saskatchewan. Its powers were wide and its opportunities almost unlimited. Among other things it was to administer the health services, the hospitalization acts and the several-million-dollar Hospital Fund when that was established.

Its members should have been experts with the highest qualifications of training and experience. The act did not specify the number, the qualifications, the responsibilities or the term of office of the members. They were to be appointed by order-in-council. To begin with only three members were appointed. Two were government officials with other duties, so could be part-time members only.

The third was member and secretary, the only full-time member and for some time the only member with medical training.

Not one of the members had a degree, other academic training, or administrative experience in Public Health. For nearly a year, during which time the plans for regional services were drafted, the commission had no other members. Then, the deputy minister of health and his assistant, who should have been members (ex officio) from the first, were appointed.

Two years later, Dr. Mott, a highly qualified public health administrator, took office as chairman of the commission. (This was in September, 1946), after the inception of Regional Health Services, and the adoption of the plan for Provincial Hospitalization.

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An advisory committee, appointed to represent all sections of the public, has met so infrequently as to have had little opportunity to influence developments.

A plan for Regional Services was submitted by the commission in the spring of 1945. The province had been divided into fourteen regions, boundaries of which were outlined on a map. A pamphlet, widely distributed throughout the province, described — in glowing terms — the advantages of the Regional plan and invited people to apply for the new type of health organization.

In the past, proposals for local health services were subject to the popular vote in each community. Now, it was enacted that, on request of ten municipal councils, (or representative groups from municipalities) the minister of

health might create a Region by declaration. If he deemed it advisable he might arrange for a vote. If this was done, a majority in the region as a whole would over-ride opposition in single municipalities. Some regions included over fifteen thousand square miles, eighty or more municipalities, and populations ranging up to and over 100,000.

Within the Region, boards would be set up with administrative powers, but with decisions subject to approval by the minister or the commission. Each municipality was to appoint one member to the Board. The region, when organized, must have public health and preventive care, but the Board would decide if additional services were to be established. They might include diagnostic, medical and surgical, hospital and nursing care, drugs, and dentistry for under 16's.

The Board would estimate the cost of services and decide how the money would be raised and the costs apportioned. The act authorized either a general property tax or a head tax, with a family maximum of \$60.00, or a combination of the two. During organization of Region 1, when opposition to these types of taxes was voiced, as it had been by the whole C.C.F. party in pre-election times, the meeting was advised by the government's economic expert that proposed alternatives were not sound.

Regional public health services would be directed, staffed and administered by the province. Regional headquarters, with medical nursing, sanitary, dental and administrative staffs would be required and cars, mobile dental units and other capital equipment.

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To begin with the province proposed that the municipalities share both capital and operating costs on a fifty-fifty basis. When this proved unacceptable to local authorities who had expected free service, the province agreed to pay all the capital and two-thirds of the operating costs. At \$1.00 per head per year this would leave 1/3 of a dollar to be financed locally.

The regions are very large for public health units. Trained staffs are in great demand and very short supply. The boards are so large as to be unwieldy. With 85 members in Region 1, its board met only once a year, appointed an executive, delegated its powers

to that body, leaving the individual citizen with only remote representation on his health board. Friction has developed in some cases as to the division and exercise of authority between the board and its officials, and the director appointed by the government.

A number of applications were received for Regional organization and during 1946 several units were set up. Only one of them attempted a full range of services. This was Region 1, the area around Swift Current. As this was to be the pilot plant for Saskatchewan, if not all Canada, it deserves careful consideration. Its record will be outlined.

PILOT PLANT

DURING the summer of 1945 ten or more municipal councils in the Swift Current area passed resolutions as required requesting that a health region be organized. Region 1 was the result—an area of about fifteen thousand square miles, with a population then listed as 55,000. Public health units in other provinces are much smaller, from three to eight rural municipalities, and from 15,000 to 20,000 residents.

There were 41 urban and 44 rural municipalities and local improvement districts and with one representative from each, a board of 85 members became the regional health board, with authority subject to the approval of the Health Services Planning Commission. This body was too large to meet frequently or function effectively. At its first meeting it appointed an executive committee and delegated its powers and au-

thority to that body. The full board meets annually.

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A large part of the region was sparsely populated, with less than two people per square mile, too small a number to sustain the costs of municipal health services. Very few such services had been established. This was probably a major factor leading to a vote in favor of the Region, and in the decision to establish there a full range of regional health services.

Headquarters for Region 1 was established at Swift Current, where a building was purchased by the province. The board employs a full-time secretary-treasurer, who has several clerical assistants. The medical health officer for the Region, and the central staff of public health nurses and other personnel, occupy quarters in the same building. Current demands for public health workers of every type

far exceed the supply and the Region has to operate with about half the standard number of nurses. Much of the time of the medical health officer is spent in supervision and administrative work. Time is lost in travel because the Region is so large. This leaves less time for preventive work. For public health at least, the Region is too large a unit, or the one-man Medical Health staff is too small. Any adequate adjustment would increase the costs beyond the \$1.00 per capita per annum at present allowed.

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The curative services in Region 1 were to be diagnostic and specialist care; hospitalization; with medical, surgical and nursing care. Dentistry for children was part of the plan, too, but was integrated with the Public Health work, although it was financed by the Region.

During the pre-Regional campaign a doctor on the staff of the planning commission told an audience that the region had 20 doctors, no specialists, and a hospital bed capacity of 175. According to American Medical Association standards, he continued, there should be 35 doctors, over 60 specialists, and 325 hospital beds.

Hospitals were over-crowded and short of staff but additions then

under construction or planned added about 75 beds by the end of 1946. The number of practicing physicians increased to 29. One radiologist was employed by the Region and located at Swift Current, which was to be a diagnostic centre, but no pediatricians or other specialists are on the staff, as had been hoped for. There is no fixed capital grant for diagnostic equipment.

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Under an agreement with the District Medical Association, payment for medical and surgical care was based on the official schedule of fees, the rate being 75 per cent. less a cash discount.

The number of people who received medical and surgical care was abnormally high and hospitalization in the half year was almost equal to the fairly high rate of the whole previous year. Also, there were many out-patients. These rates were expected to level off in 1947. Students of health insurance say that a high demand for care is typical of such schemes. Local control was able to check any tendency to abuse under municipal plans.

On the whole, service seems to have been satisfactory in this initial stage. The disturbing factor in the year-end report had to do with costs.

CONFUSION OVER COSTS

CHIEF guide in estimating costs for Region 1, the first health region to be established in Saskatchewan, was the long experience of municipal health services. These costs had ranged from \$4.00 to

\$12.00 per head, annually, for combined medical, surgical and hospital care; and \$3.00 per head, or less, for hospitalization alone.

Premier Douglas, in a speech at Chaplin in 1942, estimated the cost

of complete services as slightly over \$8.00. The planning commission, in its early proposals, used an outside figure of \$13.50, which included diagnostic, specialist, and dental care — the latter for children under 16. The estimates for Region No. 1 allowed approximately \$8.00—per head for the half-year, and anticipated a surplus at that figure, of \$52,000. This should have been ample for contingencies, and for the beginning of the reserve which, in regional and provincial health financing, ought to be built up to aid in low-crop years.

The taxes adopted for the half year were a combination of the head and general property tax \$5.50 per capita, with \$30.00 family maximum, and 1½ mills.

The "family maximum" was introduced into provincial health legislation in 1938 with the head tax to protect the man with a large family. Originally \$50.00 per annum, it was raised by the C.C.F. in 1945 to \$60.00 and was again increased to \$70.00 in 1947.

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The original estimates were wrong. The population of Region 1 was estimated at the 1941 census figure. Actually it was 10 per cent. less than that. The estimate of the cash to be paid under the head tax failed to take account of the family maximum. The original planners failed to allow adequately for losses due to uncollected taxes. If the budgetted surplus was intended to cover these items it was inadequate. It seems strange that these errors were not caught by the Planning Commission, one member of which was the economic expert of the government.

Estimated receipts were \$439,865. They included proceeds of the

head and general tax, and expected grants from the province. Of the \$35,697 estimated for this last item, the Region only qualified for about half..

Actual experience proved the commission to be 25 per cent.—one quarter—wrong in its estimates of revenue. It said the income would be \$439,865. The actual income was \$329,899 with a few thousand dollars of unpaid taxes which might be collected. Right here, therefore, there was a loss of over \$100,000.

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Had the estimates been accurate the reduction in population which lowered receipts should have reduced expenditures also. But here again were miscalculations. In spite of the smaller population, actual expenditures—that is the cost of the plan—exceeded the budget figures. The cost of hospitalization was most out of line. A rate of \$4.00 per annum had been estimated, one third higher than top municipal costs for this service. Actual costs proved to be twice the estimated rate. This is a significant figure in view of the province's venture into that field.

Administration costs were also above the estimated mark, and averaged .58½c for the six months or well over a dollar per year for the centralized administration. This made nonsense out of the government's claim that a centralized administration would be cheaper than local administration.

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The total half-year deficit on the estimate of \$439,865. was \$79,374.17 plus \$29,001.51 uncollected taxes. The act was amended at the 1947 session to protect the Region from

loss due to uncollected taxes. The law now states that the municipality must pay to the Region before the end of each year a sum equivalent to the whole amount due from head taxes, a ruling which is certainly not popular in the municipal field.

The experiment in Region 1 continues. Hospitalization has now been taken over by the province. There is no provision in the estimates for any expansion in the services. They do not in any way exceed those provided by the best of the municipal medical contracts which have existed for years, and which, in other parts of the province, continue to serve a large proportion of the population. The 1947 charges were a head tax of \$10.00 with a \$30.00 family maximum, and 2 mills general tax. The hospital tax paid to the province is an additional charge. A surplus of \$63,000 was estimated in the budget. With a reported grant of \$21,000 from the province this should have been enough to cover the 1946 deficit.

Preliminary reports (to date) for 1947 were announced early in September. \$23,000 of the \$29,000 of uncollected 1946 taxes were still outstanding. Average monthly expenditures for 1947, instead of lev-

elling off, had increased. To the end of August they were, on average, about \$8,000 a month more than estimates. If this continues, for the balance of the year it will involve another deficit, even if there is 100% tax collection.

A budget for 1948 has been approved and new, higher rates of taxation set. The land tax is increased 10% to 2.2 mills; the head tax will go up to \$15.00 for single persons, \$24.00 a family of two; \$30.00 for three, and \$35.00 family maximum. Estimates of costs are based on figures well below those which prevailed in the first eight months of 1947, but no reason for this optimistic outlook was reported.

Limitation of services as a means of reducing expenses was rejected as undesirable.

Regional service definitely costs more than municipal services cost. Administration costs more. Tax collections of over 90 per cent. in 1946 suggest that in good times people can pay and do not grudge the cost. Will this be equally true in low-crop years?

The record says: No. But if payments fall off the Regional Health system will face bankruptcy.

C.C.F. HOSPITAL LEGISLATION

IN Saskatchewan over 130 municipalities had tax-paid municipal hospital schemes prior to 1940. Most of the hospitals were owned by municipal or union-municipal bodies. They had experience to contribute and they had a vested interest in maintaining their own schemes until something less costly, or more efficient could replace them.

Until recently, legislation which affected public bodies like the municipalities, the hospitals and the professions, would not have been prepared without preliminary study in which their representatives had a share. A statutory board or commission would have been set up with defined duties and authority and the municipal and other associations, the public,

as well as the province would have had member representation. Such a board would probably have been continued as a permanent advisory body at least during the early years the acts were in force.

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Under the C.C.F. government, a temporary commission was established to aid in drafting the Hospital Standards act and the Provincial Hospital Nursing and Medical associations were asked to appoint members. But no such body was created to advise the government and the legislature with respect to hospitalization.

The Hospitalization act is compulsory. No vote was taken to approve the plan. No provision is made whereby communities which had municipal service at lower cost might elect to continue that service and obtain exemption for these residents from the provincial hospitalization tax. Individuals, already covered by the type of hospital insurance they preferred, could not exercise any choice. Railwaymen, covered by provisions which are part of their wage system, must still pay the fee. Student nurses, a small group with little money to spare, entitled to care in the institutions where they trained, were not exempt from tax. The minister has power to make exemptions, but there are few.

Most of the act is concerned with the hospital tax, its collection, the fines and penalties in case of delinquency. Here the act is clear, specific and detailed. If the individual fails to pay, the province may collect from his employer, and both may be fined or imprisoned for delinquency.

The rest of the Act is a skele-

ton, filled out by innumerable Orders-in-Council, which have in turn been amended, cancelled, defined by regulations, until it is difficult for anyone to know what the Act requires or permits. Practically all authority is centred in the provincial government and delegated by it to the Health Services Planning Commission.

Registration and tax collection were delegated to municipal authorities. They involved considerable work and a five per cent. commission on collection defrays this cost. Tax revenue is paid into a central fund, which is administered by the Health Services Planning Commission. Hospital cards are issued to those paying the fee. Municipalities may enforce collection, a provincial responsibility they will not willingly assume.

Nothing in the act specifies how service is to be provided. The province assumes no responsibility for this, the Premier himself telling the people that the act does not guarantee service. Local authorities must continue to be responsible. The principle, adopted elsewhere, that hospital facilities should be built up district by district, and the fee imposed and areas brought into operation under the act only when the district was in a position to provide the care paid for, was not incorporated.

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Much of the hospital care provided under earlier schemes is now defined by regulations as "out-patient" care and is not entitled to benefit under the act. This is a restriction on service, but other restrictions, imposed in some municipal plans are not operative in the provincial scheme. To date the

service provided, including referrals to "outside" institutions, is about the same as that obtainable under the best of the municipal contracts, except for the limitations in regard to out-patients.

A separate act was passed to establish new hospital standards on which public ward rates for payment to hospitals would be based. All hospitals will be graded. Each receives a basic number of points and additional points are scored for varying standards of staff, service, equipment, therapies, etc. The resulting rates vary for each hospital and are also graduated according to length of the patient's stay. After the first ten days, payment is reduced 41c a day, with a similar reduction after twenty days. Costs of operation have increased from 20 per cent. to 50 per cent. or more in the last year or two, and an upward revision in the original basic rate has been asked to cover this.

While this act is designed to encourage higher standards, it involves a rate structure which must complicate records and accounting for the central administration.

The Health Services Planning Commission is empowered to administer the Hospitalization act, the Hospital Standards act and the Hospital Fund as well as the Health Services act. It may advise the minister, approve, disapprove, regulate, confer, hold inquiries, conduct hearings, act as referee in certain types of dispute, employ

staff, assign duties, delegate powers, appoint tax collectors (for the Hospital tax) etc. etc. Its members are appointed by and responsible only to the government.

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Among the regulations it may make are those defining hospital service to which beneficiaries under the act are entitled. It may also regulate the location, construction, equipment, operation, employees, records and accounting system, of hospitals.

Asked, on attaining power, if the government intended to "take-over" the hospitals, Premier Douglas reassured inquirers and told them that ownership would remain unchanged. This continues to be true. Local authorities and church groups still own the hospitals. The burden of capital costs, the problems of administration, accentuated by the new system, the provision for operating deficits, which have not disappeared, are still theirs. What is lost is local autonomy. They own but do not control the hospitals.

Provincial hospitalization benefits those who, previously, had no form of hospital insurance. It increases the cost to those who were protected under municipal or other plans. It is a huge undertaking, and faulty and weak foundations may imperil the whole structure if the time comes when it is subject to strain. Its cost, compared with that under municipal plans, is staggering.

MORE PROMISES

WHILE much has been heard of the C.C.F. achievements in regional health services, more is claimed for its hospital care pro-

gramme. Only two years in office and the Socialist government, we are told, has found money to pay for free hospital care for all in case

of need. No other government in Canada, or in North America, so the claim goes, has done as much.

Are these claims justified? Are people provided with better and cheaper service than before? Has the burden of hospital costs been lifted? Was it wise not to wait for a Dominion health insurance policy?

Again, it is necessary to review the background. What was the situation in the spring of 1946 when the act was passed?

In rural Saskatchewan hospitals take second place only to doctors as essentials to health service. Distances are too great, a doctor's time too valuable to be spent in driving. Bed-patients needing continued medical care need hospitalization too.

Each year the demand for hospitalization has grown. By 1945, approximately 118,000 out of a total population of 845,000, were hospitalized. Over 200,000 people, mainly rural, were entitled under various public schemes to pre-paid hospital care. Large urban groups were enrolled in other hospital care plans. It is clear that extension of hospital service had its roots in the municipal hospital system. But no provincial wide service could be created merely by passing a law to authorize it. Were there facilities available to provide the care?

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Until 1940 hospital extension had been steady and continuous. Even in the thirties, the increase in bed capacity totalled 40% for the decade. In 1940 it was checked by the war, although the demand continued to grow. Instead of expand-

ing, hospitals met the increased demand by crowding in more beds and patients. At the end of 1945 the actual beds exceeded the normal bed capacity by more than 22%. Much building would be needed merely to overtake this. In all, space for over 2,000 beds, or a 50% increase was needed. Municipalities have frequently been told by Premier Douglas that this is a local responsibility.

Hospital beds were not only inadequate in number, they were unevenly distributed in proportion to population. This is evident in a listing of bed capacity by regions in 1945. Taking the rates per thousand of population, two regions had 6, most had from 2 to 3, while one had only 1.5. For the new government hospitalization policy, 7 beds per thousand were necessary. In September, 1946, a few months before service was to begin, Premier Douglas assured people that the shortage would be overcome speedily. Building in 1945 and 1946, plus what was planned for 1947 would, he said, round out a two-thousand bed programme. Much of the 1945 programme is still unfinished and about a thousand beds, altogether, not two thousand, will be in use before 1948.

The shortage of nursing and other hospital staff was equally serious. It had been impossible to build staff up to standard and any growth in the service would require a comparable expansion in all kinds of employees.

So much for the physical aspects of the Saskatchewan hospitalization plan. The element of cost will be dealt with in a subsequent article.

HOSPITALIZATION COSTS

FOR twenty-five years prior to the election of the C.C.F. party, the municipalities of Saskatchewan operated tax pre-paid local hospital systems. The phrase tax pre-paid means this: the people of the municipalities operating hospital systems were taxed for them each year. If last year's taxes were paid, the resident and his family were entitled to care. The interest of these taxpayers in their local hospitals was keen. Control was exercised by municipal officials. Operating costs were low. Abuses were promptly noticed and closely checked.

Services were paid for at public ward rates, usually under a contract between the municipalities and the hospitals. The municipality knew on what hospitals it could depend for service and what charges it would have to meet. The hospital knew what communities it was to serve, what accommodation would be required, and at what rates it would be paid. Non-residents received care theoretically at their own charge, or their municipalities, but often failed to meet this obligation, imposing a burden on the hospital authorities.

The average annual cost of the municipal hospital services was about \$3.00 per capita.

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When the Saskatchewan government decided to take the plunge in an over-all health service it appointed a planning commission to prepare the ground. This commission, with the municipal experience at hand, estimated the annual cost for hospital care at \$3.50 per head of population.

The proposed service, however, was to be broader than the local municipal services. Therefore, the Hospitalization act, when it was passed, declared that the annual tax for this service "must not exceed \$5 per capita" and must be limited to \$30 per family. The municipalities agreed to collect the tax.

Rural municipal officials were slow to react to the new legislation but by the time the tax had to be collected its implications were disturbing, particularly in areas which had their own hospital schemes which cost much less. Substitution of the per capita hospital tax for their own smaller levy was most unwelcome. Specific cases will explain why.

In the municipality of Parkdale, the increased cost was 35 per cent. In the municipality of McKillop the increase was about 80 per cent. The municipality of Connaught provided a population of about three thousand with medical, surgical, x-ray and hospital care, for \$12,021.40 in 1946. In 1947, with hospital care paid for under the new provincial health plan, total costs will be over \$19,000.00 and there was no improvement in service.

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Connaught's average cost in 1946 under the old system was \$4 per head of population. This was paid for by the municipality and it included 3½ mills in the general tax rate to cover it. Thus a man with a small farm and a large family paid little. In one actual case a man with his wife and six children paid \$9.80 per year as part of the ordinary land tax. This man under the new health

plan will have to pay \$30 to the province for hospital care alone and the local tax for medical and surgical care. On the other hand a large land owner who paid substantial sums at the 3½ mill rate as part of his ordinary land taxes, now pays much less than before, because he pays on the head tax basis with the family limitation.

These are the strange results brought about by the new policy. Many similar instances could be quoted from municipalities in every part of the province.

But this was not the end.

It speedily became clear that the \$5. head tax imposed by the Hospitalization act would not support the cost of the new plan. Experience for the first half of 1947 proved that the cost would not be much less than \$8. per capita or \$6,500,000 per year for the whole of the province. Seldom before have events so quickly shown lack of business experience and judgment in a government. Mr. Douglas, who a few months before had assured the public that a tax of \$5. per capita limited to \$30. per family would support the service, now said that the receipts from the tax would be about \$3,500,000 and expenditures under the policy over \$6,000,000. In the Saskatchewan News of Sept. 22 (a government publication) the expenditure for hospital bills for this year up to July 31 was given at \$3,613,000. This would work out at \$6,200,000 for the year.

And there will be substantial additional costs for the central office of the plan. A central office was never required when the municipalities were running their own shows. The new central office pays

a 5 per cent. commission to municipalities for the collection of the head tax. This works out at \$180,000 per year. Then there is a hospital tabulating service provided by the central office at a reported cost in salaries and wages of \$17,000 per month or more. The central office has installed electrical accounting machines and other costly equipment. The total cost of the central office will approximate \$500,000 per year. Added to the main item of \$6,200,000 this produces an over-all cost of \$6,700,000 per year.

To recapitulate:

Under the former Saskatchewan system of municipal hospital service the cost on average was \$3 per head. It was paid in the ordinary municipal land taxes, or in a few cases by a per capita tax.

Under the new C.C.F. system the cost is working out at \$8. per head or \$6,700,000 for the whole province. How this is to be paid is anybody's guess. The provincial head tax of \$5. for each man, woman and child (not to exceed \$30. per family) will bring in about \$3,500,000. The apparent gap between income and outgo is \$3,200,000 per year. Just over a million dollars was voted from the treasury to help pay this, one third of what is needed.

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Where has this money gone? What are the people of Saskatchewan getting for it?

It is claimed that many more people are being served. In 1945, 119,600 people were hospitalized, or nearly 10,000 per month. Eleven thousand per month is the rate quoted officially for 1947 — a ten per cent. increase. The average time in hospital has been reduced.

Thus it seems that Saskatchewan under the new policy is paying \$6,700,000 instead of the original estimate of \$4,000,000, to have 11,000 people instead of 10,000 people per month in hospital. An increase in cost would be understandable, but why more than \$3 millions?

The answer will not be available until the figures on expenditures are tabled at the next session of the legislature. All that is clear now is that a centralized administration

is very costly. It requires complicated tabulations in all cases and it imposes very great additional expenses upon the local hospitals to keep up the records for the head office. All this bookkeeping, of course, is non-productive.

Perhaps the most regrettable thing is that so much money is being used up on the hospitalization plan that other phases of the health policy — medical and surgical services — may well be postponed indefinitely.

EXCESSIVE COST

IN three years the Saskatchewan government has travelled all the way from a faith in the power of legislation to create public services to a realization that personnel, equipment and adequate money are essential. Public services do not spring magically out of the printed page of a statute. The idea that, having passed a statute, a government may dust its hands and walk off, saying, "Thank goodness that job's done"—this idea does not work. The Saskatchewan government should know by this time that there is no use passing laws unless the means to implement them are at hand.

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The beginning of the health service policy was the decision to divide the province into fourteen regions, each of which would be a complete, self-contained unit of preventive and curative services, including medical, surgical, hospital and specialist care. The government, said Premier Douglas, would go ahead with its plans if necessary without the aid of Do-

minion Health Insurance. With the Dominion, a fairly complete service could be set up in about two years. Without the Dominion, it would take four.

Today, only one of the 14 regions is operating the full range of services. There are none of the specialist "trimmings." Costs are very high compared with municipal service of a comparable range, and a serious deficit has been incurred.

Four other regions have started to organize public health and preventive care services. Tentative proposals are being considered in two more regions. Step by step progress may be expected in the other seven regions later. It will take two or three years, possibly longer, to get this one phase of the original regional health policy established. The difficulty of getting qualified personnel, doctors and nurses especially, is the delaying factor.

The Health Services Act still enables a regional board, when established, to decide that it wants

diagnostic, or medical and surgical care and to try and organize it. But the enthusiasm with which this was advocated by the Planning Commission in 1945 and 1946 is a thing of the past.

All the observer can see today of the original, much-talked-about, unparalleled regional health services, is the experiment in Region I, with its legacy of deficit millstones to trouble it; and the public health programme by regions which resembles the public health units of other western provinces, except that the latter have smaller units and more of them.

There is also hospitalization. This is a service everybody wants because hospital bills are a burden to all but the wealthy, or the insured. It was to be free, *but it is not free*. It was to be a better service that the municipalities gave. *It is not a better service, and it costs more than twice as much in taxes*. A centralized provincial administration was to cost less. *It costs more in the individual hospital and is extravagantly costly at the centre*. Prior to this policy, there was no central office. It has taken much of the authority and the control of hospitals from those who built and operated them, but it has not taken away the burdens and the responsibilities.

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Experts in planning were to design a better service, with less limitations than the municipalities could provide. Experts in administration were to see that it cost less and that the tax burden would be lighter than a butterfly's wing. It is true that some people have

protection who did not have it before, but for those who had it before, provincial costs are much heavier, for just the same care. And these higher taxes do not pay the whole toll. With the centralized control, costs are more than twice what municipal costs were and the province, which means the people who live in it, is burdened with a huge deficit.

There is a grave shortage of hospital accommodation, and two years were lost before an effort was made to work out a plan for construction in the province. Hospitals have been built, some of them with provincial grants-in-aid, which are too small, in the words of the director of hospital planning, to be operated with economy and efficiency. The province which collects the fee does not assume any responsibility for providing the care. The principle, adopted elsewhere, that no fee should be imposed until the service it paid for was available, is not admitted in Saskatchewan. The other traditional policy, that individuals should be allowed to choose whether they would, or would not be under the plan, was set aside. The scheme is compulsory. Neither municipality nor individual may remain out, even though they have equal or better protection for less money.

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Apart from the burden on provincial finance which is a serious result of centralization and of introducing the service before due preparation had been made for it, the excessive cost of hospitalization will be a blow to the hopes of all those who want complete health services.

The more money absorbed by hospitalization, the less will be available to establish medical, surgical and other needed care. Waste and extravagance in one field are obstacles to development in others.

Plans for general progress in Saskatchewan may well have been wrecked, for the time being, by the haste and improvidence with which provincial hospitalization was introduced.

